

# duty of care

'dju:ti ɒv,(ə)v keɪ:

noun

A moral or legal obligation to ensure the safety or well being of others

**First Do No Harm : The ethics of transgender healthcare**

**MAY 2019**

“primum non nocere”

Dr Lord Moonie was elected as the member of parliament for Kirkcaldy in 1987. During his time as a Labour MP he served as Minister for Veterans at the Ministry of Defence. Upon his retirement in 2005 he was created a life peer and took his seat in the House of Lords.

Prior to entering national politics he had a career in medicine, spending time specialising in psychiatry and pharmacology before entering community medicine, whilst also serving as a councillor on Fife Regional Council.

He says:

“I am sponsoring this event in the House of Lords for Standing for Women because I am concerned about the growing number of individuals, especially children, who are being diagnosed with gender dysphoria and with the treatment that is currently available to them. We need to be able to examine the efficacy and potential harms of all medical approaches. The current political climate has made this nigh on impossible as any questioning of transgender ideology is shut down as bigotry. We are duty bound to question any new treatment protocols that do not have proven outcomes. First do no harm”

Standing for Women are most grateful to Lord Moonie for facilitating this important discussion.

## **Introduction**

Dr Lord Lewis Moonie

## **Towards compassionate science based medicine/care for gender questioning individuals.**

Richard Byng

GP and Professor of primary care medicine at the University of Plymouth

## **Freedom to think: the need for thorough assessment in gender dysphoria**

Marcus Evans

Psychoanalytic Psychotherapist, Member British Psychoanalytical Society and The Institute of Psychoanalysis

## **Medical Harms of Gender Affirmative Therapy**

Michael K. Laidlaw, MD.

Endocrinologist

## **An Urgent Call to Action to Protect Young People and End Experimental Identity Medicine**

Kelsey Coalition consultant

## **The Spread of an ideology and the targeting of children in UK schools**

Stephanie Davies-Arai

Author, teacher trainer, parent coach and Founder of Transgender Trend

## **Q & A**

lead by Dr Lord Lewis Moonie



## Richard Byng

GP and Professor in Primary Care Research,  
University of Plymouth.

In his academic role Richard specialises in developing and evaluating interventions for excluded groups; he also works in a mental health team for young people with emerging personality disorder.

Professor Richard Byng has worked as a GP since 1995, and is a GP with a Special Interest in Mental Health working in the Icebreak young peoples 'emerging personality disorder' service. He has been involved in redesign of services, education, commissioning and policy development, setting up the first health care based Time Bank in the UK. He leads primary care research at the University Plymouth and has built up a research Group of 50 individuals since 2009 based on major grants from NHS National Institute of Health Research. He specialises in the development and evaluation of complex interventions for marginalised groups and those with mental health problems. In the last year he has worked with a group of experienced doctors across the UK to highlight concerns about the rapid increase in treatment provision for gender questioning young people despite the deficits in evidence.

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### Towards compassionate science based medicine/care for gender questioning individuals

There has been a major rise in referrals for mainly young people to Gender identity services. This appears to be, at least in part, due to changes in culture and beliefs of young people, fuelled not insignificantly by on line fora. Our major concern is for vulnerable young people and the potential for overall harm indicated by the case studies of actual harm and the limited evidence base. In this talk I will outline some key issues and then propose an alternative approach based on an understanding of the evidence and standard practices in medicine.

I am here as a generalist doctor and researcher with expertise in developing person centred care for vulnerable groups. I work as a GP and in a young people's mental health team so now regularly encounter gender questioning young people on various points of the pathway to medical intervention. These have included individuals disappointed about the limited effects of hormones on beard growth or body fat redistribution, feeling sexually inadequate after transition and seeking psychological support to tolerate not transitioning.

The current positions are as polarised as virtually any in medicine. It is important that all views consistent with the evidence should be aired even if not in keeping with current policy. It is important for health care practitioners to be able to speak out. The different positions reflect debates in the public sphere. I suggest that the basis for such differences amongst doctors rests on three areas of belief.

Firstly, our understanding of the body, the brain and the mind. While medicine normally sees our sexual biology as binary and fixed, much gender theory - and in particular queer theory - instead suggests that someone's belief about what gender they are is of paramount importance and should be supported by medical interventions, legal changes and increasingly education in schools. In health care in the UK a Memorandum of Understanding and other guidance is increasingly suggesting we should endorse an individual's belief that they are 'trans'. Such a position conflicts with evidence that the subjective psychological experience of being 'trans' is changeable rather than fixed; and that there is no objective way for a doctor to declare someone is 'trans'. Rather we should provide compassionate support rather than endorse biologically unsound beliefs such as 'being born in the wrong body'.

Secondly, our approach to decision making varies. There is a conflict between a purely consumerist approach to giving people whatever medicine they want in relation to such beliefs, and current normal practice of shared decision making. Uncertainties, harms and benefits of the options should be discussed along with the hopes of patients. Often, when harms are likely to be small, the patient's choice will be respected. But doctors are not expected to provide surgery and medicine on demand; rather we have a duty of care to weigh up potential harms and benefits before intervening or providing interventions for vulnerable people. For example opioid prescribing for chronic pain is now an area where the expectation is for doctors not to prescribe in response to patient requests - though until recently such prescribing was just one of a litany of medical 'innovations' now shown to be harmful. The new model of so called 'informed consent' for so called 'gender affirming' treatment - including via private online clinics - is therefore in conflict with standard medical practice. It does not appear that the uncertain risks of treatments are always fully shared with young people, and the use of language seeks to minimise the significance of treatment, such that double mastectomy is relabelled 'top surgery'. There is a danger that such consumerist approaches, along with unthinking 'support' for marginalised or vulnerable groups, results in harm.

Thirdly, doctors can interpret evidence differently. For the last 50 or more years a small group of dedicated doctors have forged the practice and evidence to support gender medicine. With relatively little resource (compared to cancer for example) they have generated a body of evidence which describes physical changes before and after intervention along with the surgical and medical techniques. This is in many ways impressive, but unfortunately lacks the normal requirements of evidence to support the introduction - let alone provision at scale - of medical advances. Randomised trials are absent or small and follow up 'too short' such that in the review of evidence carried out by Professor Carl Heneghan from Oxford University's Centre for Evidence Based Medicine it was concluded that 'The current evidence does not support informed decision making and safe practice'.

A coming together of these three factors - over selling of the current evidence for benefit, an unscientific thinking about the body and gender and a consumerist approach to decision making - along with changing beliefs and cultures among young people appear to have led to an escalation in referrals as well as BOTH an increase in treatment provision AND also distressing waiting lists. Unfortunately, the ambitions of the Tavistock GIDS service to be developmental and trauma informed might have been weakened by these factors. The case for change is generally accepted, but while NHS England propose expansion to deal with demand, we are concerned about the harms of applying a relatively poor evidence base to a new and expanding cohort of younger mainly female individuals with different psychological profiles - much more rapid onset and with autistic trait and past trauma.

And as well as poor evidence for benefit we also have very little on which to quantify the potential harms. But we do have a duty to hypothesise as to how harms could occur in transgender medicine and try to mitigate these. Individual case study evidence shows all the following possible/likely:

1. Physical side effects - short and long term
2. Emotional problems - neglect of mental health issues, emotional development, disappointment about unfulfilled physical expectations
3. Social - difficulties - family discord, lack of partners

Detransition can incorporate all of above. The speakers following me have the experience and expertise to illustrate these in detail.

So what do we make of this and how do we move forward to ensure we have the best service in the world for gender questioning individuals? I believe that one reasonable position to take given the state of the evidence is that:

*All medical and surgical interventions for those under 25, still very much in a developmental phase, should be halted, except under research conditions, with randomised controls, and with independent monitoring. Instead we should provide compassionate person centred psycho-social support.*

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Given that we need to be realistic - such a change is unlikely in near future - we should consider how to mitigate potential harms while advocating for such a stance:

1. Prevention - acknowledge that gender questioning and feeling trans are influenced by complex mix of cultural norms and personal predispositions (related e.g. to trauma and autism trait) - this means we should stop encouraging people to believe they are trans and stop school based education, and other socialisation (e.g. guides etc). More general work in schools should explain why many girls are socialised to feel uncomfortable or even disgust with their bodies because of problematic gendered roles and past trauma. Effects might include cutting, anorexia or wondering if they are 'trans'.
2. Provision of accurate information - NHS and websites of medical authorities and also charities need to mention potential harms, uncertainties and not glamourise transition or sexual stereotypes.
3. Endorse a person centred and scientifically accurate approach to practitioner interactions in specialist and non-specialist settings: exploring links between complex cognitive, emotional and social issues; talking accurately - distinguishing between biologically male/female bodies and the experience of feeling 'trans' or not being sure; exploring decisions in terms of balance of benefits and harms; separate affirmation of an individual's experience from being equated to being recommended and having a right to medical intervention. This will require a rewrite of the Memorandum and provision of guidance applicable to private as well as NHS service services by the GMC.
4. Add to current proposed NHSE service specifications key services for which there are gaps for which there are gaps, with ongoing evaluation: additional conservative supportive strategies - individual or group based support for individuals come to terms with biological bodies while expressing whatever (non gendered) role they wish; increased psychological input for the 17-25 year olds who will need a developmental trauma informed services as commissioned in GIDS; neutrally framed support for those on waiting lists provided on basis that some individuals will desist; services for those who have desisted and detransitioned.
5. Take advantage of the current recommissioning of adult services and create an ongoing long term cohort research study with independent scrutiny for all those presenting as questioning and entering services - with outcomes measured and assertive follow up those lost dropping out of care. Ensure the GIDS and adult services as well as private provision is joined up as one database. Use such a cohort should fully investigate the cause of the rapid change in presentation and bio-psycho-social profile of younger individuals.

*These are my own views and may differ from those of the University of Plymouth, The Adelaide and St Levan Surgery, The Zone or the NHS National Institute of Health Research.*



## Marcus Evans

Psychoanalyst, and a former Consultant Adult Psychotherapist in the Tavistock and Portman NHS Foundation Trust, was Associate Clinical Director of the Adult and Adolescent departments from 2011 and 2015.

He has 40 years' experience in mental health originally training as a psychiatric nurse.

He was Head of the nursing discipline between 1998-2018. Marcus has designed, developed and taught outreach courses for front line staff in various settings for the last

25 years. He was also one of the founding members of the Fitzjohn's Service for the treatment of patients with severe and enduring mental health conditions and/or personality disorder in the adult department, this service is directed by Dr David Bell.

He has written and taught extensively, and has considerable experience in understanding the processes that impede or promote development in institutional settings.

He is the author of 'Making Room for Madness in Mental Health: the psychoanalytic understanding of psychotic communications' published by Karnac in Tavistock series. After retiring from the NHS in 2018, Marcus took up a post on the Council of Governors of the Tavistock and Portman HNS trust. He resigned from this post over the trust's management of complaints about the Gender Identity Disorder service.

## Freedom to think: the need for thorough assessment in gender dysphoria

Dr Bell a senior consultant in the Trust and a Member of the Council of Governors was approached by 10 staff from the service who all had grave ethical concerns – inadequate assessment, patients pushed through for early medical interventions and an inability to stand up to pressure from lobbies. A letter to the trust board from a concerned group of parents whose children had been treated by the service raised similar concerns, claiming that children were being 'fast tracked' to medical interventions. In response to these, complaints the trust asked the medical director to conduct a review. During the next six months, I witnessed a sometimes subtle, at others not so subtle attempt by Trust management to dismiss or undermine the serious concerns raised both by Dr. Bell's report and the letter from the group of concerned parents. I have learned that dismissing serious concerns about a service or clinical approach is often driven by a defensive wish to prevent painful examination of an 'overvalued system'. In contrast to this dismissive attitude, communication between different perspectives is an essential ingredient of a healthy psychological system. I have previous knowledge and experience of the way in which closing down debate and discussion creates silos that resist thoughtful examination of important issues. This is a particularly worrying approach to the GID unit because it is treating vulnerable individuals and families who are making decisions which often have far reaching, and as yet not fully known, consequences for their lives.

People in the field often report that patients who undertake medical intervention for Gender Dysphoria have high levels of satisfaction and make a good transition. However, this claim does not tally with research or with my own experience with my own or others experience. I used to assess adult parasuicides admitted to casualty during the late 1980s. A number of patients were admitted having taken an overdose, post Gender Reassignment Surgery. Amongst many things, they were often angry at the loss of their biological sexual functioning. They were aggrieved with psychiatric services, whom they felt had failed to examine their motivations for requesting reassignment surgery or to adequately investigate their psychological difficulties.



I used to assess adult parasuicides admitted to casualty during the late 1980s. A number of patients were admitted having taken an overdose, post Gender Reassignment Surgery. Amongst many things, they were often angry at the loss of their biological sexual functioning. They were aggrieved with psychiatric services, whom they felt had failed to examine their motivations for requesting reassignment surgery or to adequately investigate their psychological difficulties.

As a psychotherapist, I consulted to various Adult Mental Health Services over the management of patients with challenging behaviours. There have been quite a few examples of patients who had a history of either serious and enduring mental illness or personality disorder, developing a late-onset Gender Identity Dysphoria. A common theme in their presentations was a belief that physical treatments would remove aspects of themselves that caused them psychic pain. When the medical intervention failed to remove their psychological problems, the disappointment led to an escalation of self-harm and suicidal ideation, as resentment and hatred towards themselves was acted out in relation to their bodies.

About 12 years ago, there was an investigation into the service prompted by complaints from staff in the GIDs at the Tavistock. The concern was that children were being prescribed hormone blockers too quickly and without a sufficiently rigorous psychosocial examination of their beliefs and thoughts about their gender and any medical/surgical interventions. As we know, childhood and adolescence is a developmental process and all individuals experiment with different identifications, including both male and female ones, as part of this. This can stir up all sorts of confusions, doubts and conflicts. When these forces become overwhelming, they may push the individual to focus on a fixed solution in an attempt to reduce feelings of confusion - one of which might be "I'm that sex, not the one I was born with". The experience of being dislocated from one's body which is changing is not uncommon in adolescence and touches on anxieties associated with the transition from child to adulthood. It is essential to tolerate these confusions and try to prevent early foreclosure.

The clinician needs considerable experience and clinical maturity to be able to empathise deeply with the individual's confusion, distress and mental pain, yet resist the pressure to join them in their view that active medical (rather than psychological) intervention is the only solution. Whatever decisions are made regarding active medical treatment in the long term, again, a thorough psychotherapeutic and psychiatric assessment is an essential part of helping both young people and their clinical teams make informed decisions about treatment and care of these vulnerable children. This involves a process of opening up a dialogue with the individual about who they are, 'what makes them tick' and what issues they may be struggling with - crucially, trying to understand what role they believe gender plays in their personality. It is also important to register that although they may decide in the long term to transition, they cannot entirely eradicate the biological realities of their natal birth and have to find some way of living with the losses involved. In this way assessment can help the individual think through the social psychological and biological implications of medical intervention.

The pressure from pro trans lobby groups that Dr. Bell mentioned in his report interferes with the freedom of thought necessary to understand the individual. When this happens, the patient undergoing assessment becomes a symbol for a political group that see themselves as battling against prejudice. In this environment thorough investigation and freedom to think is prohibited by politically driven accusations of transphobia and conversion therapy. This deprives the individual of the space they need to think things through with In this environment thorough investigation and freedom to think is prohibited by politically driven accusations of transphobia and conversion therapy. This deprives the individual of the space they need to think things through with an experienced and impartial clinician.

We do not fully understand what is going on in this complex area and it is essential to examine it from different points of view. This is difficult in the current environment as the debate and discussion required is continually being closed down or effectively described as "transphobic". This accusation serves a need to shut down thoughtful enquiry something that absolutely needs to be secured so that we can protect children from being harmed.



## Michael K. Laidlaw, MD

Board certified Endocrinologist from the United States.

His works concerning medical harms to children and adolescents treated with hormones and surgeries for gender dysphoria have been published in the Endocrine Society's journal JCEM (The Journal of Clinical Endocrinology and Metabolism) and the American Journal of Bioethics as well as in on-line publications. He also serves as the medical consultant to the parent led child and young adult advocacy group the Kelsey Coalition which advocates for their transgender-identifying children who have been harmed by the medical profession. Most recently Dr. Laidlaw and colleagues recommended on behalf of the Kelsey Coalition that the Office of Human Research Protections in the United States have a moratorium on harmful research being done to children and adolescents involving radical hormonal manipulations and surgeries to "treat" gender dysphoria.

### Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline"

Michael K Laidlaw Quentin L Van Meter Paul W Hruz Andre Van Mol William J Malone

*The Journal of Clinical Endocrinology & Metabolism*, Volume 104, Issue 3, March 2019, Pages 686–687, <https://doi.org/10.1210/jc.2018-01925>

Published: 23 November 2018 (reprinted with permission)

Childhood gender dysphoria (GD) is not an endocrine condition, but it becomes one through iatrogenic puberty blockade (PB) and high-dose cross-sex (HDCS) hormones. The consequences of this gender-affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy (1, 2).

There are no laboratory, imaging, or other objective tests to diagnose a "true transgender" child. Children with GD will outgrow this condition in 61% to 98% of cases by adulthood (3). There is currently no way to predict who will desist and who will remain dysphoric. The degree to which GAT has contributed to the rapidly increasing prevalence of GD in children is unknown. The recent phenomenon of teenage girls suddenly developing GD (rapid onset GD) without prior history through social contagion is particularly concerning(4).

GnRH agonists are used in precocious puberty to delay the abnormally early onset of puberty to a physiologically normal age. The goal of PB in the healthy child, however, is to induce hypogonadotropic hypogonadism to "buy time" to confirm gender incongruence. In a study of PB in adolescents aged 11 to 17 years, 100% desired to continue GAT. They simply "bought" themselves lower bone density and the need for lifelong medical therapy (5).

Studies show that 5% of adolescents receiving GAT even attempt fertility preservation(6). Those started on PB at Tanner stage II, as recommended by current guidelines, will be blocked prior to sperm maturation and ovum release. They will have no prospect of biological offspring while on HDCS hormones and continuing on to gonadectomy.

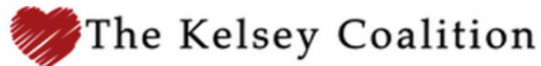
The Endocrine Society's guidelines recommend elevating females' testosterone levels from a normal of 10 to 50 ng/dL to 300 to 1000 ng/dL, values typically found with androgen-secreting tumours. The ovaries of women given testosterone correspond to those found in PCOS, which itself is associated with increased ovarian cancer risk and metabolic abnormalities (1). Venous thromboembolism risk is elevated fivefold in males taking estrogen (2).

The health consequences of GAT are highly detrimental, the stated quality of evidence in the guidelines is low, and diagnostic certainty is poor. Furthermore, limited long-term outcome data fail to demonstrate long term success in suicide prevention (7). How can a child, adolescent, or even parent provide genuine consent to such a treatment? How can the physician ethically administer GAT knowing that a significant number of patients will be irreversibly harmed?

Hypothesis-driven randomised controlled clinical trials are needed to establish and validate the safety and efficacy of alternate treatment approaches for this vulnerable patient population. Existing care models based on psychological therapy have been shown to alleviate GD in children, thus avoiding the radical changes and health risks of GAT(8). This is an obvious and preferred therapy, as it does the least harm with the most benefit. In our opinion, physicians need to start examining GAT through the objective eye of the scientist-clinician rather than the ideological lens of the social activist. Far more children with gender dysphoria will ultimately be helped by this approach.

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Leila Leoncavallo has worked since 1994 on an array of public interest matters including food law, nutrition policy, educational reform, school curriculum, and child advocacy. She was a senior staff attorney for the Center for Science in the Public Interest, one of the oldest independent, science-based consumer advocacy organisations in the United States. She volunteered as a Court Appointed Special Advocate for children and serves as the government liaison for Dyslexic Advantage, one of the world's largest communities of dyslexic people with over 70,000 members.

In 2012, Leila founded Fairfax Dyslexia (tutoring and advocacy services for children with dyslexia) and CivicsEd.com (curriculum and instruction designed for intellectually gifted students with learning challenges.) In 2019, she began serving as the policy and legislative consultant to the Kelsey Coalition, a new grassroots group in the United States representing approximately 300 parents and caregivers whose transgender-identifying children have been medically and/or psychologically harmed.

Leila is a member of Phi Beta Kappa, graduated summa cum laude with Highest Honours from the University of Rochester with a Bachelor of Arts in psychology and earned her Juris Doctor degree from the University of Virginia School of Law. She was admitted to the Virginia State Bar in 1994. Leila has served as a volunteer docent at the US Supreme Court since 2010 where she provides weekly lectures in the courtroom about the Court's history and function.

## **An Urgent Call to Action from the US: End Experimental Identity Medicine**

We are witnessing an unprecedented number of young people who see themselves -- and want others to see and treat them-- as if they were the opposite sex, or no sex at all.

They may be young boys who prefer feminine clothing and toys, teenage girls who declare they are transgender soon after adolescence begins, or young adults who suddenly announce they are non-binary. Incongruent gender identities are now assumed by young people across all ages, appear in a variety of contexts, and emerge for many complicated and poorly understood reasons.

The feelings and pain of young people are real. They deserve respect and compassionate evidence-based care. Instead, they may be ridiculed and shamed; or on the other extreme, have their gender identities quickly affirmed by their parents, teachers, and therapists without consideration of underlying issues. Most alarmingly, young people are commonly treated by physicians with invasive and poorly researched medical interventions. Nowhere is the medicalisation of identities more concerning than in the United States where children as young as eight years old receive hormonal treatments, and those as young as 13, irreversible surgeries.

Research focused on investigating underlying causal factors and developing non-medical therapeutic protocols is desperately needed, but prevented by ideologically based activism. Instead, nearly all research is limited solely to medicalising these identities with hormones and surgeries at increasingly younger ages. As a result, underlying issues are often ignored, while identities are medicalised before non-medical options are explored. It is unconscionable that harmful hormonal treatments and risky irreversible surgical interventions have been deemed the standard of care when psychological approaches have never been studied for their efficacy. Schools are often the first place where children may begin to suspect that they have been born into the wrong body. State-mandated curriculum sometimes requires teachers to instruct students that their sex was assigned to them by a doctor when they were born and that it is up to them to decide their gender identity. Professional associations have advised teachers not to notify parents when children request a change of name and pronouns.

When parents try to get help for their children, they have difficulty finding a therapist who will not quickly affirm their child's identity without a thorough assessment. Parents report being pressured by health care professionals to consent to risky medical treatments. Some young people first declare that they are transgender soon after beginning university. Young adults are especially vulnerable to unscrupulous practitioners, and can be just as susceptible to outside influences. They can easily obtain hormones from informed-consent clinics where medical history and mental health assessments are not typically required. Hormone and surgical treatments are often covered under their university-sponsored health plans.

Even minor children may obtain medical treatment without their parents' knowledge. In the state of Oregon where the age of medical consent is only 15 years old, parental permission is not legally required for hormonal treatments or surgeries. Cost is no barrier because medical transition services may be covered by the government-funded Medicaid program. One mother described what happened to her daughter in Oregon:

At the age of 17, without my consent or even knowledge, my daughter was able to change her name and gender in court, obtain testosterone treatment, a double mastectomy, and a radical hysterectomy. Recently, surgeons performed another irreversible and risky procedure, a radial forearm phalloplasty, on my now 19-year old daughter. They removed parts of her arm to surgically construct an imitation penis. My once beautiful daughter is now homeless, living in poverty, bearded, sterilised, and extremely mentally ill, but not receiving any mental health services. She tells me that she is in constant pain. The level of heartbreak and rage I am experiencing as her mother is indescribable.

These experimental identity-based medical practices on young people must not be allowed to continue.

### **Presentation to the House of Lords**

#### **First Do No Harm: The Ethics of Transgender Healthcare**

**London, United Kingdom May 15, 2019**

We are witnessing an unprecedented number of young people who identify as transgender or non-binary. They see themselves — and want others to see and treat them — as if they were the opposite sex, or no sex at all. Their feelings and pain are real. They should be treated with respect and compassionate care. Instead, their gender identities are being quickly affirmed by teachers and therapists — regardless of age or underlying issues — and most alarmingly, often treated by physicians with invasive, risky, and poorly researched medical interventions. Nowhere is the medicalization of young people's identities more concerning than in the United States where children as young as eight years old receive hormonal treatments, and those as young as 13, irreversible surgeries.

School is often the first place where children begin to suspect that they may have been born into the wrong body. State-mandated curriculum sometimes requires teachers to instruct students that their sex was "assigned to them" by a doctor when they were born, but that it is up to them to decide their gender identity. Teachers have been warned not to notify parents when their children request a change of name and pronouns.

When parents try to get help for their children, they have difficulty finding a therapist and report being pressured by health care professionals to consent to risky hormonal treatments. One couple described how they took their 13-year old daughter to a prestigious university's gender clinic for an assessment. Within just a few hours, and with no consideration of mental health or medical issues, the gender clinician informed them that their daughter was transgender and they should start her on testosterone that very day.

One mother reached out to countless doctors and counsellors, but found that the only ones willing to help her daughter are those who push her to medically transition. She wrote:

Our daughter, at around age 15, began to think that she was transgender. She said she likes boys, but also believes she is a boy. It is difficult to get any help — other than from those who affirm that she should pursue medical treatment. We've talked to doctors and psychologists we know, off the record, who've expressed to us their opinion that taking hormones long term and that removing breasts and ovaries is gravely harmful to the majority of young people, but that laws keep their "hands tied."

Our daughter is now 17 and is considering transitioning to a boy as soon as she turns 18, believing lifelong treatment of testosterone, permanent body-altering surgeries, and sterilization is the answer.

These parents have struggled for over three years as they tried to find help for their daughter. They wrote: Our daughter is now 17 and is considering transitioning to a boy as soon as she turns 18, believing lifelong treatment of testosterone, permanent body-altering surgeries, and sterilization is the answer.

These parents have struggled for over three years as they tried to find help for their daughter. They wrote:

When our daughter expressed the desire to be male three years ago at the age 12, we allowed her to choose an androgynous name, cut her hair short, and bought new clothing because we wanted to support her during a difficult time. We thought it would be a short-lived phase. We wanted to explore where these feelings were coming from, but everyone we consulted pushed unquestioning affirmation. She spoke with her teachers about being transgender and changing her name. They concluded she should come out to classmates to explain what being transgender is. We were not informed. Instead of encouraging our daughter to love herself as she is, her school and therapist encouraged her to socially transition to a male, which is far more challenging for a child to reverse than anyone can comprehend. When we told our daughter's therapist that we were not comfortable using a new masculine name, she said we were doing irreparable damage to our child. She wears a binder to flatten her breasts all of the time. It seems to have made her more insecure about her body. We are concerned about the effects of constant binding that includes decreased lung capacity and back pain. We constantly search for support to help our child, but we do not believe that hormone treatment and surgeries will improve her quality of life. Looking back, we see how online influences, the school counsellor, and therapist all encouraged our daughter to move away from the support and love of her family. She was being told that we didn't understand or care. Nothing could have been further from the truth.



This letter is from a mother whose concerns were dismissed, and whose daughter was harmed, by the therapist she trusted to help.

During the confusing and emotional stage of puberty, my daughter thought she was a boy. I took her to a gender therapist and was shocked to learn there was no test, no diagnosis, no criteria beyond a child's feelings during puberty to verify whether or not her self-diagnosis was accurate. When I questioned this, the therapist dismissed me as a transphobic parent.

I felt completely discriminated against and stereotyped as a typical mother who had a problem accepting a trans child. It was a horrible experience I will never forget.

Even worse is that there are no guarantees that underlying causes for the dysphoria are explored, like my daughter's deep grief from suddenly losing her father in an accident.

**Instead, the therapist ushered my daughter into his youth trans support group and recommended a colleague, a doctor, who put her on puberty blockers on the first visit...and testosterone on the third visit.**

Parents of young adults are also concerned. Their children are arguably even more vulnerable to unscrupulous practitioners, and can be just as susceptible to outside influences as when they were young. Many young people first declare that they are transgender soon after beginning university where hormones can easily be obtained from informed-consent clinics. Medical history and mental health assessments are not required. Hormone and surgical treatments are often covered under the university health plan. Parents are blindsided, shocked, and utterly helpless as their young adult children are quickly medicalized. These are excerpts from a few of their testimonials:

—My daughter transitioned at age 18 as a college freshman. Her university directs students who identify as transgender to an informed consent clinic. At the second visit, she received a prescription for testosterone. Soon after my 20-year old son made the shocking announcement that he was transgender, I made an appointment to see the college campus therapist. I asked her to look into other mental health issues. She said no. She wasn't required to do so.

—I asked her to help my son feel comfortable in his body to avoid life-long medication and surgeries. She said she couldn't do that either — that was considered conversion therapy and that was illegal in New Jersey.

--- Soon after settling into her dorm room to begin her sophomore year, my daughter called to inform me she is "transgender." She had already been taking testosterone. She subsequently gave up her dreams of a college education, severed ties with her family and within a few months was seen for a consult for a double mastectomy.

--- Instead of recommending therapy for my son, a young man who has not only experienced extreme grief and trauma throughout his short life, but has terminal cancer, the university clinic directed him to begin feminizing hormone treatments. Aside from whether or not my son is transgender, these hormones would certainly hasten his demise. I knew very little about the transgender issue until a few weeks ago, and what I have learned has shocked me. I have learned that there is no real research to support putting a young man like my son on hormones, that there is no consideration for his health risks, and that there's no protocol to diagnosis this, and no attention paid to the underlying issues like trauma. The doctors are treating these young people with hormones, even kids like mine with terminal cancer.

In the US, minor children may also obtain medical treatment on their own. In the state of Oregon, where the age of medical consent is only 15 years old, children may receive risky hormonal treatments — and even surgical interventions — without their parents' permission. It should be noted that money is no barrier because these medical transitions may be paid for by the government-funded Medicaid program.

This is what happened to one mother and her young daughter.

At age 14, after suffering multiple traumatic events in her young life and spending a large amount of time on the internet, my daughter announced that she was "trans." Her personality as a sweet, loving girl changed almost overnight. At first, I thought she was just going through a phase. But the more I tried to talk sense into her, the more she dug her heels in. Around this time, I came to realize that my daughter exhibits many signs of being on the autism spectrum. I expressed my concern to mental health "professionals," who seemed mostly interested in helping her process her new identity as male and to get me to accept the notion that my daughter is actually my son. They diagnosed her with ADHD, depression, and anxiety. I was advised that amphetamines were the best option for her. I declined.

At age 16, my daughter found a pediatric endocrinologist who taught her to inject herself with testosterone. Soon after, she ran away to Oregon. I was left with no valid options to stop her. In Oregon, at the age of 17, without my consent or even knowledge, she was able to change her name and gender in court, obtain testosterone treatment, a double mastectomy, and a radical hysterectomy.

My once beautiful daughter is now 19 years old, homeless, living in poverty, bearded, sterilized, extremely mentally ill, but not receiving any mental health services. Instead, surgeons performed another irreversible and risky procedure on my young daughter: a radial forearm phalloplasty: They removed parts of her arm to surgically construct a fake penis. My daughter tells me that she is in constant pain. The level of heartbreak and rage I am experiencing as her mother is indescribable.

This is a child whose body has been irreversibly transformed, and who will likely experience medical complications, and one day, tragic regret. In what other medical field do physicians rely on the self-diagnosis of children — particularly mentally ill children — as the basis for serious hormonal treatments and drastic surgeries? When else do healthcare professionals treat young people with life-altering medical interventions without a single long-term study to support their use?

**We must stop this.**



## Stephanie Davies-Arai

Accredited communication skills trainer,  
writer and author of the book  
*Communicating with Kids*.

In 2000 she was a founder of a successful small primary school in Lewes where she was a governor and consultant for eight years. She has delivered courses and workshops for parents and teachers for over twenty years.

From 2013 -15 Stephanie was a prominent member of the No More Page 3 campaign, speaking on female objectification at schools, universities and organisations including Girl guiding and the Institute of Public Policy Research.

Stephanie has delivered presentations on the subject of transgender children in schools and at events across the UK and appeared numerous times on TV and radio. She founded Transgender Trend in 2015 and produced a schools guide Supporting gender variant and trans-identified students in schools in 2018, for which she was shortlisted for the John Maddox Prize which “recognises the work of individuals who promote sound science and evidence on a matter of public interest, facing difficulty or hostility in doing so.”

Stephanie contributed a chapter to the best-selling book *Transgender Children and Young People: Born in Your Own Body*, edited by Heather Brunskell-Evans and Michele Moore, published in 2018 by Cambridge Scholars.

<https://www.cambridgescholars.com/transgender-children-and-young-people>

<https://www.transgendertrend.com/>

<https://stephaniedaviesarai.com/>

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## The spread of an ideology and the targeting of children in UK schools

Over the past decade we have seen an exponential rise in the number of child and adolescent referrals to the Tavistock Gender Identity Development Service. This must be viewed within the context of the current worldwide cultural obsession with 'gender identity,' driven by a global transgender activist movement. Labelling children 'transgender' politicises the child. Whereas a child with gender dysphoria may be helped and supported, the 'transgender child' becomes an emblem of a social justice movement and may be used to provide 'proof' of an ideology in order to further wider political goals.

The groups providing professional training for both the NHS and teachers, such as GIRES, Mermaids and Gendered Intelligence, are not clinical or educational professionals or child development experts, but lobby groups at the forefront of shaping public policy and government legislation for the whole of society. They are heavily funded by government departments and lottery grants and they advise and provide training for the police, the Home Office, the EHRC, the CPS and the Prison and Probation service.

These groups promote an extremist ideology through two key campaign aims: to replace biological sex with 'gender identity' as the cultural and legal distinction between men and women and to establish 'affirmation' and social transition as the only legitimate approach towards children with gender dysphoria. This goal involves the indoctrination of all children into the essentialist ideology of 'brain gender' that activists campaign to enforce throughout society.

From picture books in the Early Years classroom to CBBC documentaries targeting 6 - 12 year-olds, children are being taught that to be a boy or a girl is a choice and that their internally held subjective feelings override their biological sex, which is merely 'assigned' to them at birth. Children are learning in school that they have an innate 'gender identity' which they need to explore in order to find out if they are male or female. Transgender schools guidance enforces the collusion of teachers in the adoption of the affirmative approach and the denial of objective biological reality.

We see young people being groomed by activists on social media, encouraged to reject their families and told "we understand you." We know children are being coached online on how to get hormones, to use the threat of suicide, and to condemn their parents as transphobic if they don't immediately 'affirm' them. Schools guidance encourages teachers to promise confidentiality, facilitate a child's transition behind their parents' backs and direct the child towards transgender support groups. A child who identifies as transgender is placed outside safeguarding and outside parental protection, leaving them vulnerable to influence from external agencies.

The targeting of children by activists has had stark results. In 2009/10 there were 56 referrals of boys and 40 referrals of girls to the Tavistock clinic. In 2017/18 there were 713 boys and 1,806 girls. This represents a 1,173% increase in referrals of boys, or over 11 times, and a 4,415% increase in referrals of girls, or over 40 times. Rapid onset of gender dysphoria in adolescent girls, with no history of gender dysphoria in childhood, is a previously unheard-of presentation; it is a newly created phenomenon for this generation.

Historically, adult transsexuals were predominantly male, comprised of two distinct groups which have been scientifically well studied for decades. Autogynephilia (to be sexually aroused by the thought or image of oneself as a female) is the most common motivation for sex reassignment treatment. The rare condition of childhood-onset gender dysphoria was mostly experienced only by a much smaller group of homosexual transsexuals. Treated with a cautious 'watch and wait' approach, only around 15 - 20% of this group persist to become transsexual as adults. The far more likely outcome is that these children will grow up to be gay. Through affirmation, social transition and puberty blockers, we are now creating psychologically and medically manufactured persistence rates.

Unquestioning affirmation is not a neutral act of kindness, but an intervention that actively shapes and changes a child's development. Social transition by trusted adults forms or reinforces a child's sense of themselves and their perception of reality. The child's brain is impacted by life experience and environmental factors. Living, and being affirmed daily as the opposite sex will affect and change neural pathways, creating a self-fulfilling prophesy of persistence.

Social transition has already been found to be the most powerful predictor of persistence in a 2013 research study by Dr Thomas Steensma from the Netherlands.

The lobby groups who aggressively campaign for the affirmative approach are the same groups who lobby the NHS for earlier and earlier medical intervention for children.

We know now that taking puberty blockers virtually guarantees progression to cross-sex hormones. Young women who regret the serious and permanent changes to their bodies after taking testosterone ask "why did no-one tell me I could never actually be a boy?" The body-hatred and disassociation not uncommon in adolescent girls has found a new conceptual framework. Mind/body disassociation, previously recognised as a symptom of trauma, has been recast as heroic expression of the 'authentic self.'

Validation of inner feelings as reality, casting the body as an inconvenient mistake, means that the body may then be treated with contempt. When we fail to protect the child's body, children are put at risk. As a result, we are seeing irreversible harms done to young, healthy bodies; predominantly female bodies, lesbian bodies, the bodies of young people with autism, mental health problems, and troubled backgrounds or trauma, including past sexual abuse.

These are our most vulnerable young people. I have witnessed the appalling damage this wreaks on families who find their child mechanically repeating dogma, and bear witness to their worsening mental health after they 'come out' as trans.

It is time to stop using children as test subjects for queer theory. Serious concerns have recently been raised by clinicians in the UK, Denmark and Sweden. Let the UK take the lead in recognising the status of childhood, in protecting children from ideology masquerading as fact, and in stopping this medical experiment on children's bodies and psychological experiment on children's minds.  
Stephanie Davies-Arai

The full article, with references, is published at <https://www.transgendertrend.com/>



## The spread of an ideology and the targeting of children in UK schools

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The groups providing professional training for both the NHS and teachers, such as GIRES, Mermaids and Gendered Intelligence, are not clinical or educational professionals or child development experts, but lobby groups at the forefront of shaping public policy and government legislation for the whole of society. They are heavily funded by government departments and lottery grants and they advise and provide training for the police, the Home Office, the Equality and Human Rights Commission, the Crown Prosecution Service and the Prison and Probation service.

These groups promote an extremist ideology through two key campaign aims: to replace biological sex with 'gender identity' as the cultural and legal distinction between men and women and to establish 'affirmation' and social transition as the only legitimate approach towards children with gender dysphoria. This goal involves the indoctrination of all children into the essentialist ideology of 'brain gender' that activists campaign to enforce throughout society.

From [picture books](#) in the Early Years classroom to [CBBC documentaries](#) targeting 6 – 12 year-olds, children are being taught that to be a boy or a girl is a choice and that their internally-held subjective feelings override their biological sex, which is merely 'assigned' to them at birth. Children are learning in school that they have an innate 'gender identity' which they need to explore in order to find out if they are a boy or a girl. They are taught that only they know who they are and nobody else has the right to ask, a message which is a staple of transgender political campaigning. Transgender schools guidance enforces the collusion of teachers in the adoption of the affirmative approach and the denial of objective biological reality.

We see young people being groomed by activists on social media, encouraged to reject their families and join their new rainbow family where "we understand you." We know children are being coached online on how to get hormones, to use the threat of suicide, and to condemn their parents as transphobic if they don't immediately 'affirm' them. Schools guidance encourages teachers to promise confidentiality, facilitate a child's transition behind their parents' backs and direct the child towards transgender support groups. A child who identifies as transgender is placed outside safeguarding and outside parental protection, leaving them vulnerable to influence from external agencies.

The targeting of children by activists has had stark results. In 2009/10 there were 56 referrals of boys and 40 referrals of girls to the Tavistock clinic. In 2017/18 there were 713 boys and 1,806 girls. This represents a 1,173% increase in referrals of boys, or over 11 times, and a 4,415% increase in referrals of girls, or over 40 times. The male/female ratio reversal has happened worldwide and the group inflating these unprecedented referral figures is teenage girls.

Rapid onset of gender dysphoria in adolescent girls, with no history of gender dysphoria in childhood, is a previously unheard-of presentation; it is a newly-created phenomenon for this generation.

Historically, adult transsexuals were predominantly male, comprised of two distinct groups which have been [scientifically well studied for decades](#). Autogynephilia (to be sexually aroused by the thought or image of oneself as a female) is the most common motivation for sex reassignment treatment. The rare condition of childhood-onset gender dysphoria was mostly experienced only by a much smaller group of homosexual transsexuals. Treated with a cautious 'watch and wait' approach, only around 15 – 20% of this group persist to become transsexual as adults. The far more likely outcome is that these children will grow up to be gay.

If we apply the past 15 – 20% persistence rate to the 96 children referred to the Tavistock in 2009/10 we can estimate that less than twenty persisted to become transgender as adults.

In 2017/18 from a total referral number of 2,519 and a rate of 45% of over-twelves going forward to the clinic, the eventual persistence rate will have increased exponentially. We know now that taking puberty blockers virtually guarantees progression to cross-sex hormones. Puberty blockers were introduced specifically to treat a particular group of children whose gender dysphoric feelings had persisted since early childhood, and prior to 2010 were not given before the age of 16 in the UK. Teenagers developing gender dysphoria at the onset of adolescence have not 'persisted' in any sense, which means that puberty blockers are now being given to a cohort who do not fulfil the original criteria for this treatment.

Lobby groups claim that past desistance rates have been debunked; that those children who desisted were not really trans anyway, they were only gender non-conforming. This does not explain the decrease in the number of children who turn out to be simply gender non-conforming and the vast increase in the number of children who turn out to be 'transgender' over the past decade. Gendered Intelligence have been going into schools since 2008 and over the ensuing decade more and more lobby groups have joined them in planting the idea in the heads of impressionable children that gender non-conformity = trans.

Through teaching this new model of understanding to children in schools, together with a policy of affirmation, social transition and puberty blockers, we are now creating psychologically and medically manufactured persistence rates.

Unquestioning affirmation is not a neutral act of kindness, but an intervention that actively shapes and changes a child's development. Social transition by trusted adults forms or reinforces a child's sense of themselves and their perception of reality. The child's brain is impacted by life experience and environmental factors. Living, and being affirmed daily as the opposite sex will affect and change neural pathways, creating a self-fulfilled prophesy of persistence.

Social transition has already been found to be the most powerful predictor of persistence in a [2013 research study](#) by Dr Thomas Steensma from the Netherlands.

The lobby groups who aggressively campaign for the affirmative approach are the same groups who [lobby the NHS](#) for earlier and earlier medical intervention for children. Young women who regret the serious and permanent changes to their bodies after taking testosterone ask "why did no-one tell me I could never actually be a boy?"

The body-hatred and disassociation not uncommon in adolescent girls has found a new conceptual framework. Mind/body disassociation, previously recognised as a symptom of trauma, has been recast as heroic expression of the 'authentic self.'

Validation of inner feelings as reality, casting the body as an inconvenient mistake, means that the body may then be treated with contempt. When we fail to protect the child's body, children are put at risk. As a result, we are seeing irreversible harms done to young, healthy bodies; predominantly female bodies, lesbian bodies, the bodies of young people with autism, mental health problems, and troubled backgrounds or trauma, including past sexual abuse.

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It is time to stop using children as test subjects for gender identity and queer theory. Serious concerns have recently been raised by clinicians in the UK, Denmark and Sweden. Let the UK take the lead in recognising the status of childhood, in protecting children from ideology masquerading as fact, and in stopping this medical experiment on children's bodies and psychological experiment on children's minds.

## Gender Incongruence in children, adolescents, and adults

First published in the *British Journal of General Practice*, April 2019.  
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More individuals are requesting medical assistance for gender uncertainty or dysphoria and provision of adult NHS gender identity services (GIS) is changing.<sup>1</sup> Despite minimal medical input to polarised debates, several issues are potentially concerning: reports of poor care; rapid rises in referrals of children and young people to GIS;<sup>2</sup> public conflation of biological sex with socially influenced gender roles; and extensive uncertainty in the evidence base to guide practice.<sup>3</sup> Medical practice should happen within robust human rights frameworks where individual patients always have their concerns heard. Generalists, with expertise in whole-person care, handling uncertainty and complexity, have a key role when consulted by identity-questioning and transgender individuals for routine care, gender identity concerns, treatments recommended by private or NHS services, or for referral.

Presentations with prior emotional trauma, co-existing mental or neurodevelopmental issues, or ‘bridging hormones’ requests may make primary care professionals uneasy. Without a considered approach to practice, high-quality evidence and guidance, a policy of active ‘affirmation’ and ‘treat or refer’ may lead to more people receiving medical interventions with uncertain outcomes.

### CHANGING THE LANDSCAPE

The characteristics of those seeking help are changing. In the past these were predominantly for male to female medical transition. Contemporarily, many younger people identify with a range of gender types (such as, trans, fluid, non-binary, gender-queer) and there is greater difficulty distinguishing overlaps with imaginative processes. The majority presenting before puberty desist. Some, but not all, seek interventions with uncertain long-term outcomes. There is growing demand for GPs to prescribe cross-sex hormones before specialist assessments but GMC and BMA positions differ.<sup>4,5</sup> More definitive knowledge is needed about: the causes of rapid increased referrals, especially girls and young females;<sup>2</sup> the outcomes of interventions or ‘wait and see’ policies in this new demographic; and how to practice and organise services, especially anticipating long-term health implications.

The planned recommissioning of adult GIS in England provides an opportunity to develop best practice through integrated programmes of training, research, and service redesign. Multidisciplinary approaches used within child and adolescent services might ensure that adults now being referred also receive whole-person comprehensive support. UNDERSTANDING RISE IN REFERRALS No robust analysis explains why referrals have risen so fast. While some individuals feel able to disclose earlier in a less stigmatised context, it is possible that gender identity uncertainty and dysphoria may be generated or exacerbated by societal and psychological factors, particularly during puberty. A study of concerned US parents reported their trans-identifying children had previously identified as gay, had mental health or neurodevelopmental problems, recent

onset dysphoria, or were in friendship groups with other trans-identifying individuals.<sup>6</sup> The paper drew intense criticism despite acknowledging limitations including distinguishing cause and effect. Likely, the rise is multifactorial: 35% of those seen in the Tavistock service have autism traits;<sup>1</sup> some females may favour traditional male roles; current female stereotypes and appearances may be rejected; some young females who are attracted to other females may initially believe they are transmen, but later identify as lesbians. While sexual orientation and gender identity are distinct, such confusion is now not uncommon.

### Box 1. Medical uncertainties and our response to gender dysphoria

Medical uncertainties	Response
What are the causes of gender dysphoria?	The causes of feeling uncomfortable with one’s biological sex are unclear but likely to be multifactorial and include society’s expectations of gender roles.
Is there a biological basis for the concept of ‘being born in the wrong body’?	Humans are sexually dimorphic, with rare intersex conditions being anomalous developments of dimorphic sexual classes. It is not possible to change biological sex. There is no agreed scientific basis for someone having the mind of someone from the opposite sex or being born in the wrong body.
How should a child or young person questioning their	Questioning is a normal part of growing up, as is discomfort during puberty. Young people should be encouraged to talk about their worries as they may not have other people they can trust outside of peer groups.
What do shared decision making look like in the absence of evidence?	Generalists should feel confident and supported to explore the potential links between gender questioning, emotions and cognitions, and the cultural context. Differences in views are likely to occur and provide the basis for each party to shift position.
How should we advise patients about the outcomes of medical treatments given the paucity of evidence?	Medical practitioners should be open and clear that, while satisfaction has been high for previous cohorts, we know little about the impact on physical (for example, fertility), emotional, and social (future intimate relationships) outcomes for the current younger and mainly female group presenting.

### INTERVENTION OUTCOMES

While a low-quality observational study of mainly older male-to-female full transitions has shown high levels of satisfaction,<sup>7</sup> there are no robust contemporary cohort studies of younger female-to-male outcomes,<sup>1</sup> nor of supportive, non-invasive interventions. Adolescents, who previously may have come to terms naturally with the emotional difficulties of pubescent bodies or with emergent homosexuality, may consider themselves to be 'trans' and be offered puberty-blocking drugs prior to psychoactive steroid hormones and irreversible surgery. We lack information whether these improve outcome, including reproductive consequences. Improved mental wellbeing is the main rationale for intervention though one study shows high rates of suicide after surgery.<sup>8</sup> This could be due to ineffective treatment, ongoing prejudice, or co-existent mental illness. Rates of persistence, benefits and complications, regret, and detransition, are unclear. Practitioners have been sued for not providing sufficient assessment or information.<sup>9</sup>

### PATHWAYS TO MEDICAL INTERVENTIONS

Gender-questioning individuals need protection from discrimination, high quality services, and clear information. Professionals should be able to refer to bodies of evidence and guidelines, but there is no UK guidance designed for generalists. Some international guidelines advocate 'affirming' an individual's expressed gender. The 2017 UK Memorandum of Understanding on Conversion Therapy,<sup>10</sup> signed by the RCGP (but not the Royal College of Psychiatrists), rejects formal 'conversion therapy', but also states that actions which contribute to a change to gender identity could be seen as 'covert' conversion. So practitioners might infer they should not explore wider issues or discuss harms of interventions. This would be counter to consultation models which encourage evidence sharing and leave room for differing views. Paradoxically, calls for medical intervention refer to mental distress and suicide risk, while psychiatric assessment is often rejected.

This is worrying as there are no objective tests for gender dysphoria, which has no agreed physical basis and is assessed by interview. It may be effected by social and cultural context and has the potential to change over time. In contrast to previous debates about depathologisation of sexual orientation, which led to demedicalisation, the opposite may occur here; while helping some, interventions can result in ongoing side effects and medical dependency. Medical intervention may, in effect, become another form of 'conversion,' whereby some children who would otherwise have grown up gay or lesbian receive 'gender affirming' cross-sex treatments instead. Much patient information does not fully express the known uncertainties of interventions. Many healthcare organisations and schools have been educated by charities and non-NHS groups using inaccurate information, including exaggerated risks of suicide.<sup>11</sup> NHS material contains concepts that biological sex is assigned at birth (rather than observed) and that surgery can change sex. The wide range of treatment experiences and outcomes including desistance need to be included.

For children and young people, an individualised age-and-developmental-stage approach is required. The facts in each case will influence consultation style, for example, where does the child live, and with whom? Who are the key carers? Is the child in education or employment? What are prior family values and current concerns? Are there conflicts or safety issues? Practitioners can draw on a variety of familiar consultation skills, such as seeing the child alone and together with family or trusted friends, gradually gaining insight, allowing the 'test of time'. In general, GPs will want to include parents and/or guardians in consultations, aiming for all parties to find common ground in their legal obligations under the Children's Act 1989 using the best interests test. A number of consultation approaches may be considered: use clear, respectful language and the patient's preferred form of address; take a non-judgemental person-centred approach; reflect on personal biases; allow a few appointments to explore issues and the time frame of gender-related distress, whether the individual is questioning or has firm beliefs, and how feelings of gender relate to sexuality; assess associated mental health issues such as self harm, anxiety, or body dysmorphia, as well as autism traits; enquire about relationships with family, friends, intimate partners, and online groups, and how these relate to the patient's views and wishes; remember sex is biological and fixed while gender relates to social roles; allow respectful space for differing views; share understanding of the uncertainties of long-term treatment; and share literature from a variety of sources to discuss at future meetings (Box 1).

### IMMEDIATE ACTION AND RESEARCH

Immediate action could include: examination of NHS literature on evidence and uncertainty; creation of coherent guidance for practitioners not specialising in gender identity; a national survey of doctors to understand views and concerns, and development of training to ensure practitioners are competent and understand the evidence. Well-funded, independent, long-term research is required to ensure doctors meet their ethical duties to 'first do no harm' and fulfil good medical practice. Research could include: exploration of the interplays between gender dysphoria, mental health problems, autism spectrum disorders, sexual orientation, autogynephilia, and unpalatable societal gender roles; and exploration of the different assessment and diagnosis models; trials of different strategies, including wait- and-see versus intervention for young people, puberty-blocking, hormonal, and surgical treatments. National reconfiguration of services is a chance to integrate research, service redesign, and training, with the creation of ongoing cohorts to monitor immediate and longer-term outcomes for all those referred and receiving different interventions.

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## Provenance

Freely submitted; externally peer reviewed. Competing interests The authors have declared no competing interests. DOI: <https://doi.org/10.3399/bjgp19X701909> ADDRESS FOR CORRESPONDENCE Susan Bewley Department of Women and Children's Health, Kings College London, 10th Floor North Wing, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH, UK. Email: [susan.bewley@kcl.ac.uk](mailto:susan.bewley@kcl.ac.uk) British Journal of General Practice, April 2019 171

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## **Standing For Women**

At Standing For Women we firmly believe that if the general public understood what we are doing to children, in the name of acceptance and progress, they would vehemently oppose it. We feel it is our duty to bring these issues to the fore and to not fear the silencing and bullying tactics of lobby groups and other invested parties. Some of our team have been reported to the police for asking questions about the transitioning of children. We see the medicalisation of children's distress as concerning and dangerous. We are convinced that parliamentarians, NHS trust leaders and those with a duty of care to children would not be quiet on this issue if they were aware of the long term health impact to children who have no capacity understand these implications, let alone, to consent. In the fullness of time we wonder whether those directly affected by this will be content, we wonder if they will have deep regrets, we wonder who they will blame, maybe you will ask yourself if you could have stopped it? We think this is a global emergency and all that remain silent are complicit in this attack on healthy bodies. Quite frankly, we ask where the questioning voices are and how this has been allowed to fester and grow without much of a challenge, it is quite sinister. We must always be suspicious of those things we are not allowed to speak of.

We do not believe humans can change sex, or that one can be born in the wrong body. We ask those who are reading this booklet to do your own research and see if you can find any trusted resource that says what we are doing to children is good for their health; we ask you to look into the tactics of lobby groups and see if you are happy with the way they operate; we ask you to really think about the impact of puberty on a body and if you think stopping it for years is truly reversible; we ask you if you are happy to sterilise these children; to encourage the breast binding and surgeries on vulnerable young women. We ask you to think.

Finally, Standing For Women ask each of you;

**What is your silence worth?**

With Thanks

To Dr Lord Lewis Moonie of Fife for  
facilitating this incredibly important  
discussion.

**woman**

wʊmən

*noun*

**adult human female**